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AUTHOR Denner, Bruce
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ABSTRACT

This speech discusses client advocacy, a paraprofessional service offered in many community mental health centers to help bridge the gap between therapist and client. While having an advocate on the mental health team is an attractive idea, these client advocates are quite susceptible to "corruption." The author discusses two major causes of this "corruption": (1) role confusion--the tendency for workers to slide back into doing therapy while purporting to be doing advocacy, consequently corrupting both; and (2) role instability--the destroying of client advocacy by the depersonalizing, alienating mode of organizing community mental health centers. The author is convinced that client-advocates can be effective change agents when they are not confused by the conflicting roles of advocate and therapist, and when their efforts are not being undermined by a paternalistic system. He offers several steps which can be taken to strengthen the position of the client-advocate. (Author/PC)

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Corruption of Client Advocacy in a Community Mental Health System*

Bruce Denner
Community Mental Health Program, Illinois Mental Health Institutes

Critics of traditional psychotherapy have argued convincingly that the poor and the disadvantaged benefit little from conventional insight-oriented therapy (Guerney, 1969; Cowen, Gardner, & Zax, 1967). The argument is by now very familiar. The traditional therapist is seen as aloof and as uninvolved in his client's reality, and generally not interested in such matters as paying the rent; rather, the conventional therapist is preoccupied with the client's intra-psychic life.

Recently some (Lerner, 1972; Lorion, 1973) have wondered whether the objection is valid for all types of verbal insight therapy and for all poor people. Nevertheless, there was sufficient evidence that the traditional mental health system discriminated against the poor (Riessman, Cohen, & Pearl, 1958) to warrant training a new kind of therapeutic helping agent, the client-advocate. The advocate, often a paraprofessional, is trained to bridge the gap between helper and client. He is dedicated to the task of solving reality problems and is not adverse to leaving his office to go into battle in the community setting where the problems originate. On paper this is a very attractive idea. Practically, though, client advocates are quite susceptible to corruption.

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This paper will discuss the following causes of the advocate's corruption: 1) Role Confusion - the tendency for workers to slide back into doing therapy while purporting to be doing advocacy, consequently corrupting both; and 2) Role Instability - the destroying of client advocacy by the depersonalizing, alienating mode of organizing community mental health centers.

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Role Confusion. Although the role of the client advocate can be spelled out in detail, it is difficult to distinguish clearly between behaviors appropriate to his role and those defined as "psychotherapy." Advocates, especially community workers, tend to be very ambivalent about the traditional therapeutic style. On the one hand, they tend to reject the style because it seems decadent, snobbish, and unresponsive to human misery. On the other hand, they are inclined to envy the strength of the traditional therapist who refuses to be manipulated by his client's sufferings. While community workers admire the professional who can make clever interpretations, they feel more comfortable giving direct advice. To further add to their uncertainty, advocates are encouraged not to foster dependency in their clients, but are also told to be as helpful as possible. The advocate is instructed not to interpret a client's repeated lateness for appointments but rather to arrange for a more convenient time. Yet in doing so the advocate may come to feel that he is infantilizing his client by protecting him against the reality that adults have to learn how to get places on time. The advocate must be continually avoiding both over-control and irresponsible detachment.

In a community clinic serving a black ghetto population where most clients are alcoholic, community workers struggle with the problem of clients who drink away their welfare checks without a thought for tomorrow. One worker, preoccupied with this problem, hit upon the idea of asking the welfare department to withhold the money after an excessive drunk or to give the money to the worker so that he could control the case flow in such a manner that socially acceptable behavior would be rewarded and the rest punished. While the plan was practical, it was inconsistent with the implicit anti-institutional principles of client advocacy. In this situation, the advocate was not joining his client in fighting alcoholism, but rather, out of confusion and poor judgment, he decided to function as a therapist who was prepared to influence his client

for his own good. In this setting, the worker acted like a behavior modifier. How do you explain this transformation from client-advocate to behavior modifier? While he should be fighting to reverse the conditions that lead to drinking, the worker ends by punishing the drinker. Perhaps, faced with the incredible task of altering the noxious environment that fosters alcoholism, the worker resorts to client control.

Another example from the same community mental health center. A community nurse, who sees herself as a client-advocate, found that a young man was destroying himself with barbiturates and speed. He came to her asking for medication to counter the effects of the illicit drugs. He asked for little else. She refused to give him more drugs, but could not tolerate his breaking off contact with the clinic. So she contacted a friend, the local narcotics agent, and arranged to have her client busted. She planned to precipitate a crisis which would give her more leverage in influencing him to give up drugs. Instead he went to jail. It is ironic that a client advocate utilized one of the most arbitrarily oppressive agencies as a means for controlling her client. Yet, from her viewpoint, some action was called for to prevent this young man from killing himself. It was very clear that the nurse did not casually conspire to bust her client, but decided on this strategy after considering alternate ways of helping him. The sad truth, though, is that he did not want her help. He wanted drugs. Since she could not identify with his initial goals and could suggest any other reasonable ones that she felt able to work for, she substituted some of her own. She slid back into the therapist role, a very manipulative one reminiscent of the roles assumed by some family therapists (Zuk, 1969; Haley, 1973).

Another tale from the same place. A teenage girl was hospitalized by a psychologist because he felt that at that time she could benefit most from a short inpatient stay. She want to the hospital reluctantly, but he felt that

he was advocating what was best. Later that day her boyfriend went to the outpatient clinic and angrily accused the psychologist of imprisoning his girlfriend. The psychologist told him to mind his own business, and the argument became so heated that both threatened to call the police on one another. Luckily for the boyfriend, neither did. This young man desperately needed an advocate at the clinic, but of course, he had none in the staff since they all saw him as the enemy. Was he not trying to disrupt a therapeutic program? In this particular example the entire staff of client advocates became transformed into therapists bent on protecting their right to make decisions for clients. Naturally, some saw themselves as the girlfriend's advocate. Had she been there, though, she would probably have been on her boyfriend's side.

There are lessons here. Client-advocates are easily done in by the fact that the reality problems facing most clients are much more difficult to change than the clients themselves. It is understandable that people with strong commitments to helping others, faced with intractible social conditions, resort to almost anything to increase the chance for success. And, paradoxically, their orientation to act directly upon the world, to work towards concrete real-life goals, leads them to manipulate and control the behavior of their client in the outside world. They are not content only to score gains in the consulting room by making fancy interpretations, although surely some would like to be able to do so. Above all they want real success. Perhaps, advocates need to learn to accept defeat.

Role Instability. There are client-advocates who can restrain themselves from becoming coercive therapist. Even so, these advocates in community mental health settings are often faced with a conflict between their job description and the role the systems forces them to play. Centers which include outpatient community-based clinics, inpatient services, day hospitals, and the like,

frequently are organized in the image of the factory (Denner, 1973). Community mental health theorists contend that the traditional social-welfare agencies and mental health institutions have become unresponsive to the sufferings of large numbers of people who cannot purchase care on a fee-for-service basis. The theorists conjure up a picture of a helpless person being shuttled back and forth between callous, distant workers who are affiliated with unconnected, fragmented services. The cure suggested for this Kafkaesque pattern of rejection and referral is both continuity of care, i.e., the linking of service delivery components; and client advocacy, i.e., the fighting for patient's rights to treatment and service. However, in a large comprehensive center continuity is mostly administrative and advocacy is largely epiphenomenal. Continuity is often brought about by bringing together program chiefs for periodic coordinators meetings. But since mental health practice is so vague in its method and intent, all that can usually be agreed upon are such technical questions as the number of days a patient can remain in the hospital or where a client goes after a period of time. In this way the various services take their place on the mental health assembly line, inevitably depersonalizing the relationship of staff and client. In this climate client-advocacy is illusory.

In this type of system the advocate is caught between his loyality to the system and to his clients. For example, inpatient workers, including psychologists are called "expediters" in one comprehensive center because their responsibility is too see that their clients obtain the services prescribed by the clinical team and to make certain their clients know the plans for aftercare. Because the expediter works in conjunction with the clinical workers, he has easy access to the information which must be transmitted to the client. But this closeness makes him less likely to be critical of them. The expediter is really in no position to criticize his peers. In fact, expediters usually

feel closer to their co-workers, who are more like them in background and attitudes, than to the patients, with whom they should identify. The clinicians, moreover, exploit this relationship by involving the expediter in patient management. Usually this takes the form of the clinician's asking the expediter how the patient is coming along. Since psychotic people have little credibility, any discrepancy between the patient's story and the clinician's is usually taken to mean, by both expediter and the clinical team, that the patient's judgment is still impaired. Thus, the expediter, who is supposed to be the patient's broker, winds up working for the clinicians. The expediter-advocate is co-opted by the system.

Another example from the same setting. A middle-aged black woman, living with her sister's family, would routinely be seen in the hospital lobby. She was known by the receptionist as a former day hospital patient who had long been released. The receptionist grew tired of asking the lady to leave every day and finally called the day hospital administrator. He spoke to the woman, who asked to be re-admitted to the day hospital. She missed her friends and the activity. The administrator said that it was impossible to re-admit her since she was no longer ill. The woman persisted in coming every day to the hospital lobby and eventually the day hospital administrator elicited the help of a community worker from the satellite clinic in her neighborhood. The administrator asked the worker, a person who identified himself as a client advocate, to help persuade this lady not to come to the hospital. The community-advocate agreed to speak with the woman. She told him that her sister and borther-in-law opposed her staying home alone after they went to work in the morning. Each morning they would wake her and force her to leave with them. Since they did not trust her home alone, they did not provide her with a key. She was told not to return home until the evening when both came home from work. There was not much to do in the neighborhood, and it was winter, so she decided to go to

the one place where she felt safe and where she knew there were friends and things to do. Since the community worker was not responsible to the hospital administrator, he could have sided with the former patient against the hospital system. But he did not, mostly because he agreed that only sick people should be attending day hospital. So he tried to convince the family to give this woman a key to the apartment. By taking this line of action, he was protecting the system against having to deal with the former patient's needs. He was helping to maintain the insanity of a system that rejects reasonable requests because they come from healthy people. Apparently, the community worker could so easily side with the institution because he was mystified by its rules and regulations. He actually believed that the day hospital was a specific sort of treatment, like a kind of medicine, which was only appropriate in certain dosages for certain people.

Some Recommendations. I am convinced that client-advocates can be effective change agents when they are not confused by the conflicting roles of advocate and therapist and when their efforts are not being undermined by a paternalistic system. Some obvious steps can be taken to strengthen the position of the client-advocate. Clearly, advocates are less likely to slide back into the therapist role if they are not assigned any traditional mental health responsibilities, and if they are not responsible to mental health administrators. Unfortunately, this is not common practice in community clinics that serve the poor. There staff are likely to mix advocacy with therapeutic strategies. Typically a community worker begins as an advocate working on reality problems facing a client. For example, a woman asked for help in obtaining a divorce and was provided with legal counsel and a supportive woman's group. She continued to meet her advocate to plan for her future without her husband, and yet, every now and then, she sabotaged their efforts by encouraging her husband to visit with her late at night. At this point the advocate perceived

that his client was ambivalent, perhaps neurotic, and proceeded to therapize her. From my point of view, this shift from advocacy to psychotherapy set the stage for corruption. Under the guise of doing psychotherapy, the worker could manipulate and influence his client in a way that would be unthinkable if the worker remained an advocate. Clearly, working with and for mental health professionals hastens corruption.

I would recommend a separate office of client advocacy associated with but not subordinate to a mental health bureaucracy. Advocates working out of this office would be concerned soleiy with solving practical problems and not with the client's mental health. The workers would be trained to expect people in crisis to behave inconsistently and to make unreasonable demands. But I would emphasize that the advocate's task is to sort out the relevant issues and develop a strategy that has a good chance of success no matter how deviant the client behaves. Psychotic, and other kinds of bizarre and irrational behavior would be treated like obstacles to be overcome not behavior to be changed. The advocate would be prepared to set the limits of his responsibility. When and if a client became totally irrational such that the worker could no longer count on his cooperation, the advocate would point out to his client that he cannot be effective without the client's continuing cooperation. Advocates must be prepared not to work for people they cannot understand or for people who are forever destroying their efforts.

For some, especially those who see the poor as inadequate, helpless children, this may seem to be a harsh, rejecting solution. It is my impression, though, that the poor and the disadvantaged behave no differently with their assigned advocates than the middle-class do with their hired lawyers. People always ask for help and then make it difficult for the helper. Still most people resent being placed in a patient role if they do not perceive themselves as sick. It is my impression that most working class people who come to commu-

nity clinics troubled by social and psychological problems would agree to set their psychological problems aside in order to work on the social ones. Lawyers often instruct their clients on how to best use their services. Advocates should do the same. Most people, however, would not permit their lawyer to become their therapist. Unfortunately, the poor are rarely in the position to restrain their clinic appointed advocate.

My feeling is that the original proposal for a helping agent who is concerned primarily with the reality needs of his client was basically sound. There is no question but that the poor, and the not so poor, suffer because they are not in control of their lifes. All of us are badly in need of allies. The mistake, where the program went awry, was to encourage traditionally trained mental health workers to behave like advocates and to place specially trained advocates in conventional mental health systems. In the first instance, the workers are prone to role confusion, while in the second, the workers are likely to suffer from role instability. As we have seen, when a traditionally trained worker finds that he cannot cope with his client's reality problems or when the client himself refuses to deal with the reality issues, the worker is inclined to fall back upon the strategy of changing the client. And we have seen how a specially trained client-advocate working in the context of a community mental health center is co-opted by a system based on the ideology of changing the person rather than society.

Finally, it must be recognized that just as the impulse to change people tends to block the impulse to change social conditions, programs for social change tend to de-emphasize individual differences. We are cheating the poor when we take away therapists and provide only advocates especially when they are pseudo-advocates. To my mind, psychotherapy is a unique service. But that's another story.

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